NEW YORK STATE OF OPPORTUNITY.

Justice Center for the Protection of People with Special Needs

Annual Report to the Governor and Legislature

2017

THE JUSTICE CENTER'S PROMISE TO NEW YORKERS WITH SPECIAL NEEDS AND DISABILITIES

OUR VISION

People with special needs shall be protected from abuse, neglect and mistreatment. This will be accomplished by assuring that the state maintains the nation's highest standards of health, safety and dignity; and by supporting the dedicated men and women who provide services.

OUR MISSION

The Justice Center is committed to supporting and protecting the health, safety and dignity of all people with special needs and disabilities through advocacy of their civil rights, prevention of mistreatment and investigation of all allegations of abuse and neglect so that appropriate actions are taken.

OUR VALUES AND GUIDING PRINCIPLES

Integrity: The Justice Center believes that all people with special needs deserve to be treated with respect and that people's rights should be protected.

Quality: The Justice Center is committed to providing superior services and to ensuring that people with special needs receive quality care.

Accountability: The Justice Center understands that accountability to the people we serve and the public is paramount**.**

Education: The Justice Center believes that outreach, training, and the promotion of best practices are critical to affect systems change.

Collaboration: Safe-guarding people with special needs is a shared responsibility, and the Justice Center is successful because it works with agencies, providers, people who provide direct services, and people with special needs to prevent abuse and neglect.

NEW YORK STATE OF OPPORTUNITY.

Justice Center for the Protection of People with Special Needs

ANDREW M. CUOMO
Governor

March 5, 2018

To the Governor and Legislature:

I am pleased to provide you with the 2017 Annual Report of the Justice Center for the Protection of People with Special Needs, as required by Executive Law § 560 and Correction Law § 401-a (2). This report summarizes the agency's activities and accomplishments from January 1, 2017 through December 31, 2017. It includes, but is not limited to, the following statistics and information:

- Number of reports received by the Vulnerable Persons' Central Register (VPCR)
- Results of investigations by types of facilities and programs
- Types of corrective actions taken
- Results of the review of patterns and trends in the reporting of and response to reportable incidents, and recommendations for appropriate preventative and corrective actions
- Efforts undertaken to provide training
- Description of the Justice Center's efforts to monitor the state's compliance with the statutory requirements for the provision of mental health services to inmates, including inmates with serious mental illness in segregated confinement

Additional information about the Justice Center can be found on the agency's website at www.justicecenter.ny.gov.

Respectfully submitted,

Denise M. Miranda, Esq.
Executive Director

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I. EXECUTIVE SUMMARY

The Justice Center for the Protection of People with Special Needs, now in its fourth year, continues to hone the tools it uses to protect the health, safety, and dignity of all people with special needs and disabilities. This is done in a variety of ways including: developing abuse prevention tools, providing education to stakeholders on Justice Center operations, and ensuring high quality investigation of all allegations of abuse and neglect.

To achieve its mission, the Justice Center standardized the state's systems for incident reporting, investigations, disciplinary processes for state employees, corrective and preventive actions and pre-employment background checks. The outcome of these activities are outlined in this report. In addition, the Justice Center has implemented a number of strategic initiatives to improve agency functions and address concerns with agency stakeholders in order to ensure we are protecting New York's most vulnerable citizens while also supporting the dedicated men and women who care for them.

II. HISTORY AND JURISDICTION

The Protection of People with Special Needs Act (Ch. 501, L. 2012) established the Justice Center for the Protection of People with Special Needs as an executive agency responsible for protecting the safety and well-being of the approximately one million adults and children who, due to physical or cognitive disabilities, or the need for services or placement, are receiving care from certain facilities or provider agencies that are licensed, operated, or certified within the systems of six state oversight agencies. These agencies include:

- Office for People with Developmental Disabilities (OPWDD)
- Office of Mental Health (OMH)
- Office of Alcoholism and Substance Abuse Services (OASAS)
- Office of Children and Family Services (OCFS) (State-operated programs/facilities and certain residential programs)
- Department of Health (DOH) (Certain adult homes and summer camps)
- State Education Department (SED) (Certified residential schools and programs)

(Please see: Appendix A for additional information on the Justice Center's jurisdiction.)

The agency, which became operational on June 30, 2013, serves as the state's central repository for all reports of allegations of abuse, neglect and significant incidents involving vulnerable individuals as defined in Social Services Law (SSL) § 488(1). The Justice Center maintains a case management system that tracks all reported cases of abuse and neglect to resolution, ensures all allegations are fully investigated, and makes final legal determinations on all allegations. The Justice Center's Special Prosecutor/Inspector General has concurrent authority with county District Attorneys to prosecute allegations that are criminal in nature. The Justice Center's Individual and Family Support Unit provides guidance, information, and support to victims and their families throughout the investigative process.

Through its oversight and monitoring activities, the Justice Center identifies durable corrective and preventive actions that address the conditions that cause or contribute to the occurrence of abuse and neglect. In consultation with its Advisory Council, the Justice Center also works collaboratively with a broad array of stakeholders to promote prevention strategies and to

develop guidance and tools to help facilities and programs better protect people receiving services. (Please see: Appendix D for information about the composition of the Advisory Council.)

The Justice Center operates with a staff of 420 committed professionals. The agency's front-line staff, which includes call center representatives, investigators, special prosecutors and individual and family support advocates have collectively accumulated decades of experience working with special populations at state oversight and private provider agencies and in other service systems prior to joining the Justice Center.

The activities and accomplishments highlighted in this report reflect the work of the Justice Center in partnership with state oversight agencies, non-profit provider agencies and individuals and families who, together, are effectively promoting positive changes that have resulted in a system of care where service recipients are treated with dignity and respect and those who provide services and supports are valued and supported.

III. 2017 Highlights

This year the Justice Center has focused not only on preventing abuse and neglect, and holding those who abuse and neglect our most vulnerable accountable for their actions, but also addressing some of the concerns raised by providers, direct care workers, and legislative members. The agency has streamlined processes to cut investigation times, enhanced trainings to benefit workers and service recipients, and redistributed staff to accommodate workload. A sampling of those initiatives include:

- *Enhanced Victim and Family Support:* Strengthened support services for New Yorkers dealing with the Justice Center by increasing the regional presence of Individual and Family Support Unit Staff across the state. (see page 9)
- *Workforce and Stakeholder Recognition*: Highlighted the work of four direct support professionals from across the state by presenting them with the second annual Code of Conduct Award. Also awarded the first-ever Champion Award to four individuals and one group in recognition of their support for people receiving services. (see page 8)
- *Reduced Case Cycle Time*: The Justice Center continues to work to reduce the cycle time for investigations. Since last year the Justice Center has cut the time it takes to investigate cases by 40%. This reduction has been achieved by implementing several changes including regionalizing staff, re-locating investigators to serve high-volume areas, and standardizing investigation practices across all settings. (see page 14)
- *Multi-agency Investigator Training:* The Justice Center trained over 400 investigators from State Oversight Agencies and non-state operated providers to share standardized investigatory techniques in an effort to improve the quality of investigations across the state. This training has also helped to improve cycle time for provider led investigations. (see page 7)
- *Multiple Mandated Reporter Relief*: The Justice Center has eased the multiple reporting requirement through guidance issued in June. Mandated reporters are now relieved from the requirement to report an incident where there are multiple witnesses if they know the incident has been reported to the Justice Center and know that he or she has been named as a person with knowledge of the reportable incident. (see page 8)

- *72-hour Protocol*: The Justice Center has implemented a protocol in which classification is deferred, allowing collaboration with provider agencies to gather critical information necessary to make an evidence-based decision about whether to classify an incident abuse/neglect, a significant incident, or non-NYJC. (see page 13)
- *Provider Outreach:* Held dozens of sessions with direct care staff across the state to obtain feedback, dispel myths, and answer questions related to Justice Center investigative practices. Modified the subject notification letter to address concerns it was confusing and intimidating. (see page 8)

IV. CARE AND SAFETY IMPROVEMENT INITIATIVES

A. TRAINING RESOURCES

The Justice Center offers a variety of training and support materials to ensure the health, safety, and dignity of people with special needs. In 2017, the agency focused on taking a person-centered approach to all investigations and outreach efforts. Justice Center staff led 127 on-site external trainings serving more than 1,000 people. In addition, more than 1,000 people took advantage of trainings available on the Justice Center's website. The Justice Center is working in collaboration with state oversight agencies and service providers to develop innovative and effective materials to both protect our state's most vulnerable and support the dedicated workforce who cares for them.

Forensic Interviewing Techniques

The Justice Center has expanded its "Forensic Interviewing Best Practices for Vulnerable Persons", an intensive multi-day course designed to offer practical guidance and skills on obtaining credible and reliable information during the interview of a vulnerable person that will withstand judicial scrutiny. The curriculum focuses on persons with disabilities, youth in state care, persons with substance abuse disorders, persons with mental health diagnosis and older adults. The three-day course is offered to outside law enforcement agencies as well as Justice Center staff. Nearly 100 people participated in the four sessions in 2017.

Collaborative Training with State Oversight and Provider Agencies Standardizing Investigations

The Justice Center has launched a training course designed to teach investigators at state oversight agencies and service providers the best practices for conducting investigations and writing reports to be reviewed by the Justice Center. The course includes curriculum in interviewing the incident reporter and victim, collection, preservation and documentation of evidence, investigation planning, detecting deception, evaluation of evidence, and filing investigation reports. This training standardizes the way reports are filed with the Justice Center, which has the added benefit of increasing the efficiency of case management and resolution. To date, 395 agency administrators and investigators have been trained in more than 35 sessions across the state.

Co-training with OCFS

Justice Center staff have been traveling with representatives from OCFS to provide training to state operated and non-state operated OCFS provider agencies. The training provides an overview of the Justice Center, the responsibilities of mandated reporters, and a description of what happens once a report is made to the Justice Center's hotline. The training also reviews the data relevant to incidents that occurred at these facilities. Four sessions were held in 2017. The format for the training allows participants to ask questions of both the Justice Center and OCFS presenters.

B. WORKFORCE AND STAKEHOLDER OUTREACH AND SUPPORT

The Justice Center makes protecting the rights of the dedicated workers who provide direct care to vulnerable persons a top priority. In response to the concerns raised about the detrimental impact of the Justice Center on workforce morale, the agency has engaged in a multi-pronged effort to educate the direct care workforce about the Justice Center, its duties and possible outcomes of investigations. As a result of this outreach, the Justice Center continues to develop additional informational and educational resources for the workforce and made changes to publications (e.g. the Justice Center poster) and policies (e.g. attorney representation). In 2017, the Justice Center conducted 48 outreach presentations to direct care workers, allowing them to get their questions answered directly by Justice Center staff.

Mandated Reporter Relief

The Justice Center recognized the desire from the workforce for a more streamlined policy regarding mandated reporting when there are multiple witnessed to an incident. The Protection of People with Special Needs Act requires all mandated reporters who have reasonable cause to suspect that a reportable incident has occurred to make a report to the Vulnerable Persons' Central Register (VPCR). This requirement helps the Justice Center make the most accurate determination about the severity of the incident.

The Justice Center has eased the multiple reporting requirement. The Justice Center, in partnership with its State Oversight Agencies, developed guidance regarding who must make a report to the VPCR. The guidance requires every mandated reporter who has direct knowledge of an incident and who has reasonable cause to suspect that a person receiving services has been subjected to a reportable incident to make a report to the VPCR unless: (i) he or she has actual knowledge that the reportable incident has been reported to the VPCR; and (ii) that he or she has been named as a person with knowledge of the incident in such prior report. Currently, OASAS and OMH have adopted this language in regulations; other SOAs have expressed a preference for the Justice Center to issue this guidance.

Code of Conduct and Champion Award

The Justice Center understands the importance of highlighting direct support staff and managers who demonstrate a strong commitment to the Code of Conduct and serve as an inspiration to their colleagues. The agency held its second annual Code of Conduct Awards in September. Four staff working in settings under the Justice Center's jurisdiction received the

honor. These awards provide an important opportunity for people who receive services, their families, provider agency personnel and the public to recognize and celebrate the exemplary work of staff whose actions demonstrate a commitment to the core values articulated in the Code of Conduct.

In addition, the Justice Center honored four New Yorkers and one organization with the first-ever Champion Award. The award is issued to people and organizations in recognition of their support for people receiving services under the jurisdiction of the Justice Center. Among the honorees: the first chair of the Justice Center's Medical Review Board, the National Alliance for Direct Support Professionals, a detective who provided invaluable assistance during Justice Center investigations, and a barber shop owner who called in a case of abuse she witnessed.

C. RESOURCES FOR INDIVIDUALS AND FAMILIES

The Justice Center provides guidance and support to victims of abuse or neglect, their families, personal representatives and guardians throughout an investigation. Individual and family support advocates can provide information about the reporting and investigative process, case status updates, and victim interview accompaniment. Nearly 5,000 individuals and family members contacted advocates for assistance in 2017.

The Justice Center continues to regionalize family support unit members, making them more accessible to individuals and caregivers needing assistance. In 2017, staff members were added in Plainview and Buffalo. These additions mean there is now family support staff in every region of the state.

The Justice Center website provides guidance and resources for individuals and families regarding incident notification and records access under Jonathan's Law as well as guidance about the incident reporting and investigative process. Additional resources were created in 2017. Those include:

- Death Assessments and Investigations: Guidance for Families and Personal Representatives
- Services for Crime Victims, Witnesses, and Families

Surrogate Decision-Making Committee

The Surrogate Decision-Making Committee (SDMC) program is the only program of its kind in the nation. It provides an alternative to the court system for the authorization of medical treatment. SDMC is authorized to provide consent for non-emergency major medical treatment and end-of-life decisions on behalf of people with intellectual and mental disabilities who are unable to provide informed consent for a procedure and have no family member or guardian to provide consent on their behalf. Almost 1,300 volunteers provided medical consent for more than 900 people in 2017.

D. PREVENTION STRATEGIES AND QUALITY IMPROVEMENT

The Justice Center supports the workforce by identifying and developing strategic prevention initiatives to keep everyone safe. These efforts have included creating and distributing guidance documents, resources, and training for individuals and staff to take a proactive approach to establishing safe, supportive, and abuse-free environments.

Abuse Prevention

In 2017, the Justice Center analyzed VPCR data to identify factors contributing to the deliberate, inappropriate use of restraints. This analysis led to the development of a new Spotlight on Prevention tool for service providers to help reduce the use of restraints. These resources can be found on the Justice Center's website.

Prevention and Quality Improvement

As part of the Justice Center's oversight and monitoring function, the agency reviews and conducts audits of corrective actions that stem from substantiated abuse and neglect cases to ensure facilities and provider agencies under the Justice Center's jurisdiction are taking the necessary steps to prevent incidents of abuse and neglect and improve the quality of care provided.

The Justice Center also visits and inspects facilities or provider agencies to assess quality of care, identify issues of concern and factors that have led to systemic failures and make recommendations for agencies to consider to reduce the likelihood of recurrence and improve the quality of care. In 2017, five in-depth systemic reviews were completed covering 22 individual facilities, and 500 audits of facility and agency corrective action plans were completed.

Examples:
Example 1: A review of a residential treatment program was initiated in response to a pattern of substantiated cases related to staff members' failure to maintain appropriate professional boundaries with young people receiving services, including acts of sexual abuse.

Result: The agency took immediate action to change the screening, hiring and training of staff. Agency policy changes were based on the Justice Center's sample abuse prevention policy available on the Justice Center website.

Example 2: A review of residential schools was conducted at the request of the NY State Education Department due to a concern that staff at the schools were not reporting incidents as required. The Justice Center found that staff in the programs were not sure about what to report and not all reportable incidents were being reported to the Justice Center.

Result: Training and policies were revised at each school visited and staff were retrained. The State Education Department also increased training and issued additional guidance to all approved residential schools about what to report to the Justice Center.

Example 3: Systemic problems at a residential facility led to inadequate medical care that resulted in a person in care having maggots on his tracheostomy.

Result: The Justice Center required the facility to develop a corrective action plan and required all staff to be retrained. The Justice Center conducted an unannounced visit to ensure that the facility had implemented the required changes.

V. INCIDENT MANAGEMENT

A. VULNERABLE PERSONS' CENTRAL REGISTER

The Justice Center was established after it was recognized there was no mechanism to track abuse or neglect reports, investigations, or outcomes across state agencies serving people with special needs. The Protection of People with Special Needs Act mandated a centralized reporting and incident management system. The Justice Center maintains this system known as the Vulnerable Persons' Central Register.

Reports made by telephone are received promptly and professionally 24 hours a day, seven days a week, by highly trained call center agents. The number to contact the toll-free hotline to make a report is **855-373-2122**. Language assistance services are provided free of charge. The Justice Center advises callers to hang up and dial 911 if a person receiving services is in immediate danger to ensure that help arrives as quickly as possible in an emergency situation. A web-based reporting form and a mobile application are also available for use by mandated reporters.

There are three types of reportable incidents – abuse, neglect and significant incidents.[1] A report may consist of multiple allegations and multiple subjects. Multiple reports are often made for the same incident. (Please see: Appendix B for additional information on the Types of Reportable Incidents and Non-Reportable Incidents).

11,940

Distinct reports of alleged abuse or neglect received by the Justice Center in 2017

Table 1. Total Number of Reports made to the VPCR by Phone or Web Form

Reports Made to the Justice Center	2017
Grand Total	**96,362**
Abuse and Neglect	15,950
Death	1,587
Significant Incident	34,578
Non-NYJC Incident	28,320
Not an Incident	15,927

[1] Certain deaths not involving abuse, neglect or a significant incident are also reportable, as discussed in Section V of this report.

Of the 15,950 reports of abuse and neglect received during the 2017 calendar year, 4,010 were duplicate reports of the same incident, resulting in the reporting of 11,940 distinct incidents of alleged abuse or neglect**.**

B. ABUSE AND NEGLECT: INVESTIGATIONS AND OUTCOMES

The Justice Center is authorized to investigate all allegations of abuse and neglect involving vulnerable persons over which it has jurisdiction. Incident reports are handled in one of two ways:

1. Justice Center Investigation
2. Delegation for investigation by the relevant state oversight agency

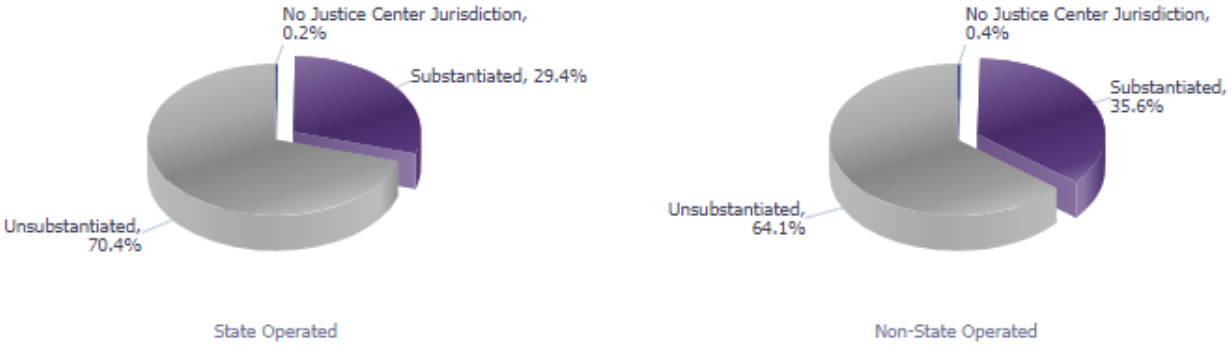
Table 2. Total Number of Abuse and Neglect Cases Closed by State Operated and Non-State Operated Facilities

	2017
Total Closed Abuse and Neglect Cases	**12,128**
State Operated Total	2,569
Substantiated	756
Unsubstantiated	1,806
No JC Jurisdiction	7
Non-State Operated Total	9,559
Substantiated	3,399
Unsubstantiated	6,127
No JC Jurisdiction	33

All reports are assessed, classified and logged into the VPCR. Each case is tracked until resolution (either substantiated or unsubstantiated), with state agencies required to report back their findings to the Justice Center in cases delegated to them. The Justice Center makes the final determination in all abuse and neglect cases.

A substantiated finding may lead to either administrative or criminal remedies, or both, when the evidence proves it is more likely than not an employee or volunteer committed abuse or neglect.

Table 3. Percentage of Substantiated and Unsubstantiated Abuse and Neglect Cases in 2017

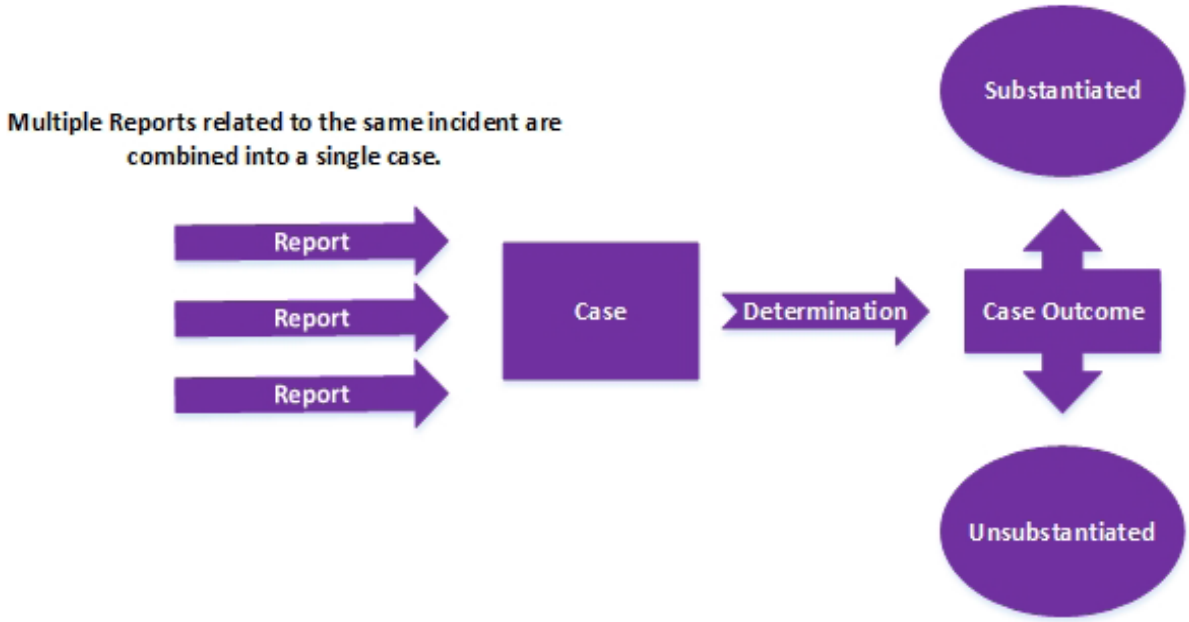


Incident Classification Modification

The Justice Center acts swiftly, based on the information reported to the VPCR, to classify an incident as abuse/neglect or a significant incident. Sometimes, shortly after an abuse/neglect case is opened, it is determined that the incident does not rise to the level of abuse/neglect.

The Justice Center has developed a protocol to delay classification of certain types of incidents in order to gather more information. This aids in making an evidence-based decision on classification (e.g., as a significant incident or a non-incident rather than as abuse or neglect). We have worked with each State Oversight Agency to identify types of cases in which there are difficulties with proper classification. The Justice Center has implemented a 72-hour assessment for certain types of OMH and OPWDD allegations. This process allows for an incident to receive a preliminary classification so the Justice Center can send an appropriate notification to the provider agency to ensure that any necessary protective measures can be instituted. Following such notification, the Justice Center works with a designated point of contact at the facility or provider agency to gather additional information and evidence to support a final classification decision. This allows the Justice Center and provider agencies to focus resources on investigating abuse and neglect cases. Benefits include increased accuracy of incident classification, reduction in the duration of time provider staff are on administrative leave, decreased number of provider staff unnecessarily being placed on administrative leave, and a narrowed scope for investigative resources thus reducing case cycle time.

In 2017, the Justice Center's Triage unit assessed 2,341 reports for OMH and OPWDD. 40% remained categorized as abuse/neglect while 47% were reclassified, resulting in faster resolution of cases. 13% were reassigned to the State Oversight Agency.



Reduced Case Cycle Time

The Justice Center has been continually working to shorten the timeframe for investigations (investigation and substantiated/unsubstantiated determination) without sacrificing their quality. The Justice Center reviews each and every investigation, whether conducted internally or by a state oversight agency or provider. Some of the changes implemented in include: opening fifteen regional offices across New York, hiring additional investigative staff in high volume areas, technology upgrades to ensure accurate information from provider led investigations is submitted to the Justice Center and implementing standardized investigation activities across all settings. Over the past year the Justice Center has targeted resources in areas related to incident management to help reduce cycle time. This has resulted in a 40 percent reduction in average case cycle time and this continues to trend downward.

Administrative Investigations

Justice Center investigators directly investigate the most serious allegations of abuse and neglect, as well as nearly all alleged incidents of abuse and neglect that occur in state-operated settings. Less serious cases are delegated to state oversight and provider agencies. Justice Center investigators and those at State oversight agencies and providers who have taken part in Justice Center training are experienced and specially trained in interviewing victims and witnesses with special needs and disabilities. They employ a victim-centered, evidence-based, trauma-informed approach to investigations to ensure victims and witnesses are treated with sensitivity, dignity and compassion.

Regardless of who will perform the investigation, the relevant state oversight agency is immediately notified by the Justice Center to ensure protective measures are put in place to safeguard the service recipient(s). The Justice Center does not make determinations about whether any particular employee may continue to work with and/or have contact with service recipients during an investigation. Those decisions are made by state and provider agencies.

Pursuant to the Protection of People with Special Needs Act, the Justice Center informs subjects of a Justice Center abuse/neglect investigation of the complaint by mailing them a letter. Staff and providers have complained that the statutorily required notification was confusing and frightening. In 2017, the Justice Center modified that letter to address these concerns. The Justice Center website also contains a document titled “What to Expect if You Are Involved in a Justice Center Investigation.”

Administrative Sanctions

The Justice Center reviews the findings of all investigations of abuse or neglect, including those conducted by a state oversight or provider agency, and makes a finding that such allegations are either substantiated or unsubstantiated. The standard of proof to substantiate an allegation in an administrative case is a *preponderance of the evidence*, meaning it is more likely than not the alleged conduct occurred.

A single case may involve one or more subjects and each subject may have multiple allegations that may involve more than one victim. The Justice Center had a substantiation rate of 34% for 2017, meaning at least one allegation of abuse or neglect was substantiated in that case.

The Protection of People with Special Needs Act incorporates the concept of proportionality of consequences by requiring the classification of the severity of substantiated abuse or neglect. Substantiated reports are put into one of four categories based on severity. As a result, the response to misconduct differentiates between serious incidents of staff culpability (Category One) and less serious incidents (Category Three), as well as incidents in which staff culpability is mitigated because of deficient workplace conditions or other factors (Category Four). (Please see: Appendix C for additional information on the categories of substantiated findings of abuse and neglect). The subject of a substantiated finding has the right to appeal a determination.

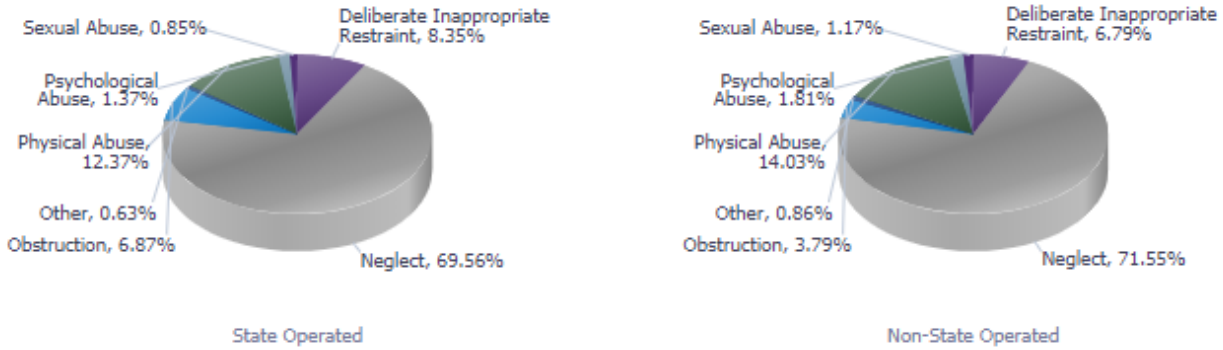
Table 4. Substantiate Cases by Allegation Type[2]

	2017
Total Closed Abuse and Neglect Cases	**4,155**
Non-State Operated Total	3,399
Category One	91
Category Two	636
Category Three	2,589
Category Four	83
State Operated Total	756
Category One	18
Category Two	159
Category Three	566
Category Four	13

Disciplinary or other employment actions are generally at the discretion of the employing provider agency in accordance with established rules and collective bargaining agreements with the exception of Category One findings. Justice Center attorneys represent the state at disciplinary proceedings brought against state employees for substantiated abuse or neglect.

Nearly three-quarters of substantiated abuse and neglect findings are classified as Category Three conduct, which means that abuse or neglect occurred but it did not seriously endanger the health or welfare of the person in care. These reports are sealed after five years and future employers do not receive any information about these incidents. The Justice Center or the state oversight agency may require the facility or provider where the incident occurred to develop and implement a plan of prevention and remediation that identifies any systemic problems that led to the determination and includes suggested corrective measures. (See IV. Prevention Strategies and Quality Improvement for additional information.)

Table 5: Types of Abuse and Neglect in State Operated and Non-State Operated Facilities in 2017



[2] "Other" includes Use of Aversive Conditioning and Unlawful Use or Distribution of a Controlled Substance.

Disciplinary Action

The Justice Center represents the State in all administrative proceedings relating to the discipline of state employees found to have committed abuse or neglect. In 2017, 239 state employees were separated from state service as a result of disciplinary charges brought against them. In addition, the Justice Center reviewed and approved 620 Notices of Discipline in 2017, which could result in an oral or written reprimand, suspension or termination.

Administrative Action Reporting Mechanism

In 2017, the Justice Center implemented the Administrative Action Reporting Mechanism (AARM). State oversight agencies (OPWDD, OMH, OCFS, OASAS, and DOH) now require their provider agencies under the jurisdiction of the Justice Center to submit information about what administrative actions, if any, the provider takes with respect to subjects of substantiated allegations of abuse or neglect. The information is submitted to the Justice Center through a web application. The new requirement allows State oversight agencies to ensure providers they license or certify are responding to substantiated allegations of abuse or neglect with appropriate corrective action.

Table 6. Completed AARM Actions by Type

AARM Action	# of Actions Completed
Grand Total	**620**
Additional Staff Supervision	12
Counseling (Formal – Written)	125
Counseling (Informal – Verbal)	26
Demotion	6
Employee Assistance Referral	2
Fine (monetary/accruals)	3
Letter of Reprimand	23
No Action	10
Placed on Probation	17
Re-training	95
Resignation/Retirement	46
Staff Reassignment/Relocation	26
Suspension (1-14 days)	27
Suspension (15-30 days)	11
Suspension (30 or more days)	18
Termination	128
Training	45

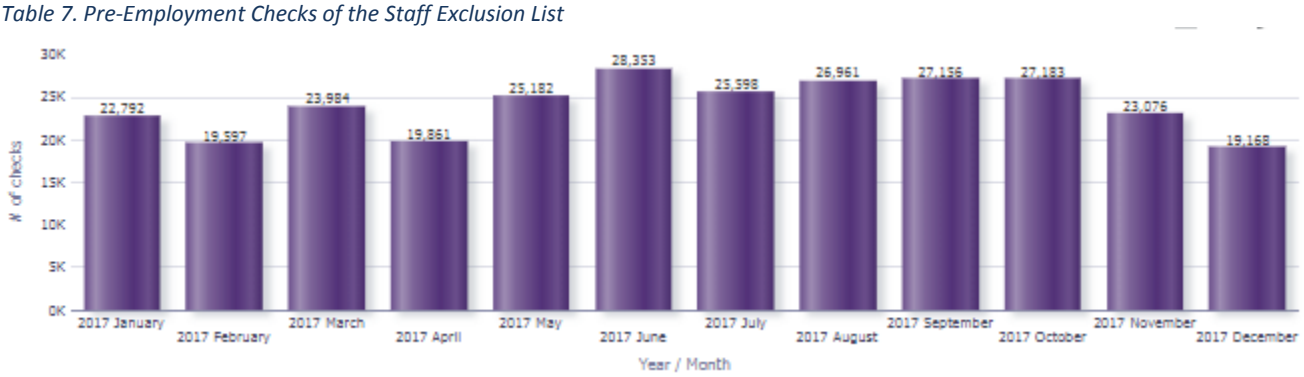
Staff Exclusion List

All subjects of a substantiated report of Category One conduct, which includes serious or repeated acts of abuse or neglect, are placed on the Justice Center's Staff Exclusion List (SEL). At the close of 2017, 398 individuals had been placed on the SEL**.** This number reflects the total number of individuals who have been barred from working in settings under the Justice Center's jurisdiction since the agency became operational on June 30, 2013. This number is an increase of 65 in the last year. Offenses that have resulted in placement on the SEL have included: hitting, choking, punching, sexual contact, falsifying records and failure to report serious allegations of abuse or neglect.

398 **individuals have been placed on the Staff Exclusion List since June 30, 2013, preventing them from securing a position in an agency that serves vulnerable populations**

Provider agencies under the Justice Center's jurisdiction, as well as certain other providers identified in statute, are required to check the SEL before hiring someone who will have regular and substantial contact with a service recipient. Since 2014, there have been 97 times a provider has been notified an applicant was on or pending placement on the SEL.

Table 7. Pre-Employment Checks of the Staff Exclusion List



Administrative Appeals

If the subject of a substantiated report of abuse or neglect requests an amendment to the Justice Center's finding, the Administrative Appeals Unit (AAU) conducts an administrative review. If the finding remains substantiated, the AAU attorneys will represent the agency at an administrative hearing. The attorneys' work includes all trial preparation. AAU attorneys work with Justice Center investigators and private provider staff for case preparation. Hearings are held throughout the State.

In 2017, the AAU received 1,486 requests for amendment, conducted 1,268 administrative reviews and prepared 561 cases for hearing.

Criminal Investigations

Allegations that meet the criteria of a criminal offense may be prosecuted by either the Justice Center's Special Prosecutor/Inspector General (SPIG) or by the country district attorney. The Justice Center notifies the appropriate county district attorney upon receipt of every case of abuse or neglect under their jurisdiction and works in collaboration with their office ensure justice for vulnerable victims and hold those who violate the law accountable for their actions. SPIG follows-up with the district attorney to offer assistance, inform the district attorney of the status of the Justice Center's investigation and to refer cases of abuse or neglect for prosecution. If an investigation results in an arrest, either by Justice Center criminal investigators or by other law enforcement agencies, Justice Center prosecutors are empowered to handle all aspects of criminal prosecutions from arraignment to trial or plea bargain.

Arrests and Prosecutions

The vast majority of cases investigated by the Justice Center do not allege conduct that would support a criminal prosecution of a custodian. The Justice Center led 49 prosecutions in 2017. An additional 99 prosecutions were led by local district attorneys. The overall conviction rate of cases prosecuted by the Justice Center is 85 percent. In addition, the district attorney and

SPIG have, in a few instances, brought joint prosecutions of criminal defendants. This collaboration ensures all available resources are used when bringing criminal charges against those who commit crimes against vulnerable persons.

It is important to note that, in addition to criminal penalties, defendants in criminal cases will have their cases administratively reviewed, which may subject them to placement on the Staff Exclusion List and cause them to face disciplinary action.

VI. DEATH ASSESSMENT

Abuse or Neglect Cases with a Death Involved

Mandated reporters under Justice Center jurisdiction are required to report to the Vulnerable Persons' Central Register any death for which they have reasonable cause to suspect abuse or neglect or significant incident may have been involved. The Justice Center notifies the appropriate district attorney and medical examiner in these cases. These deaths are investigated in the same manner as any other abuse or neglect allegation.

In 2017, the Justice Center closed 113 abuse and neglect investigation cases in which a death was involved. 66 had at least one substantiated allegation of abuse or neglect, which may or may not have caused or contributed to the death in questions. It was determined criminal charges were not warranted in any of these cases.

Executive Law § 556 Death Reviews (not abuse or neglect)

Administrators of residential programs licensed, operated, or certified by the Office for People with Developmental Disabilities (OPWDD), the Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS), and the Office of Children and Family Services (OCFS) are required to report all deaths of residents to the Justice Center, irrespective of whether the death is unusual or expected. The purpose of this reporting is twofold: to monitor and examine whether quality of care issues may have contributed to an individual's death; and to make recommendations to improve future care of service recipients and prevent the recurrence of similar issues.

All deaths subject to this mandatory reporting are referred to as Executive Law § 556 deaths and each report is reviewed by investigators with program experience and health care professionals, including registered nurses. This reporting and review is in addition to the requirements to report and investigate deaths where there is reasonable cause to suspect abuse, neglect or a significant incident.

Table 8. Total Executive Law § 556 Death Cases Completed

Executive Law §556 Death Reviews	2017
Total Reviews Conducted	**2,198**
State Operated	533
Non-State Operated	1,665

In 2017, the Justice Center completed 2,198 Executive Law § 556 Death Reviews across the four agencies required to report these deaths.

Reduced Closure Cycle Time

The length of cycle time for death reviews has been significantly reduced in 2017 due to the findings of a LEAN project. The project identified several concerns with closing death assessments including: average cycle time of 376 days, no efficient mechanism to assign cases to unit staff, a lack of detailed closure policies and products, and a lack of varied track for case treatment based on circumstances of death. After evaluation, a lack of access to death certificates was identified as a major factor contributing to the average cycle time. The Justice Center has now reached a Memorandum of Understanding with the Department of Health that will allow for immediate access of death certificates, significantly reducing the backlog of cases. In addition, providers can now electronically submit an improved Report of Death form, a new closure policy has been put into place, and there is now a mechanism to allow assessments to differ based on the cause and manner of death.

VII. CRIMINAL BACKGROUND CHECKS

The Justice Center reviews and evaluates the criminal history of all prospective employees or volunteers applying for jobs at provider agencies under its jurisdiction and advises service providers about the individual's suitability for employment. This includes the ability to request and review information contained in FBI identification records. The review provides an additional safety net for individuals receiving services and their families and mitigates risk for employers and the workforce.

Table 9. Criminal Background Checks

Criminal Background Checks	2,017
Total Fingerprints Processed	**98,323**
Total Applicants Reviewed	12,207
Denied Approval for Employment Consideration	369

In 2017, 98,323 applicants were fingerprinted. Of these, 12,207 individuals had a criminal history. 369 applicants were denied approval for employment consideration for convictions that ranged from assault to rape and murder.

VIII. MENTAL HEALTH CARE SERVICES IN PRISONS

The Justice Center monitors the quality of mental health care provided by the Office of Mental Health (OMH) to people who are incarcerated in state prisons.

The Justice Center visited 24 facilities and completed 1,225 cell-side and 134 private interviews with inmates in 2017. The Forensic Unit also reviewed the quality of mental health care for 396 inmates as well as the records of 597 inmates placed in solitary confinement in Special Housing Units (SHU) to determine if they received mental health care and assessments in accordance with the requirements of the SHU Exclusion Law.

The Justice Center found 45 percent of the SHUs visited in 2017 were not in compliance with the statutory requirements of the law because they were not completing all required mental health and suicide assessments and follow-up visits within the timeframe required by law.

The Justice Center also assess the quality of care being provided in specialized programs for prisoners with mental illness in prison. In this way, the Justice Center seeks to effect change that will promote a more therapeutic environment for inmates.

In May, the Justice Center began a year-long review of the Therapeutic Behavioral Unit (TBU) at the Bedford Hills Correctional Facility. The TBU is a program for female inmate/patients serving SHU sanctions who have a serious mental illness. The Justice Center also began a systemic review of the intermediate Care Programs in late 2017. Intermediate Care Programs are a therapeutic setting available in 13 prisons which provide rehabilitative services to inmates who are unable to function in general population because of their mental illness.

IX. CONCLUSION

Guided by Governor Andrew M. Cuomo's vision and in partnership with state and private provider agencies, individuals with disabilities, family members, and advocates, the Justice Center will build upon the accomplishments detailed in this report and continue to explore and develop new approaches to strengthen the agency's ability to safeguard New York's most vulnerable citizens in the year ahead.

X. APPENDIX A

The Justice Center oversees facilities and provider agencies within the systems of six State Oversight Agencies (SOA):

Office for People With Developmental Disabilities (OPWDD)

- Facilities and programs that are operated, licensed or certified by OPWDD

Office of Mental Health (OMH)

- Facilities and programs that are operated, licensed or certified by OMH

Office of Alcoholism and Substance Abuse Services (OASAS)

- Facilities and provider agencies that are operated, licensed or certified by OASAS

Office of Children and Family Services (OCFS)

- Facilities and programs operated by OCFS for youth placed in the custody of the Commissioner of OCFS
- OCFS licensed or certified residential facilities that care for abandoned, abused, neglected, and dependent children, Persons in Need of Supervision or juvenile delinquents
- Family-type homes for adults
- OCFS certified runaway and homeless youth programs
- OCFS certified youth detention facilities

Department of Health (DOH)

- Adult care facilities licensed by DOH that have over 80 beds, and where at least 25 percent of the residents are persons with serious mental illness and where fewer than 55 percent of beds are designated as Assisted Living Program (ALP) beds
- Overnight, summer day and traveling summer day camps for children with developmental disabilities under the jurisdiction of DOH

State Education Department (SED)

- New York State School for the Blind
- New York State School for the Deaf
- State-supported (4201) schools, which have a residential component
- Special act school districts
- In-state private residential schools approved by SED

XI. APPENDIX B

Types of Reportable Incidents

Abuse
There are seven categories of abuse**:** physical abuse; sexual abuse; psychological abuse; deliberate inappropriate use of restraints; use of aversive conditioning; obstruction of reports of reportable incidents; and unlawful use or administration of a controlled substance.

Neglect
Neglect is any action, inaction, or lack of attention that breaches a custodian's duty and that results in or is likely to result in death, physical injury or serious or protracted impairment of the physical, mental, or emotional condition of a service recipient.

Most commonly, neglect is the result of a custodian's lack of attention or failure to act as required by his or her responsibilities. Neglect can include, but is not limited to: failure to provide proper supervision; failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care; and failure to provide access to educational instruction.

Significant Incident
Any incident, other than an incident of abuse or neglect, that because of its severity or the sensitivity of the situation, may result in, or has the reasonably foreseeable potential to result in harm to the health, safety or welfare of a person receiving services.

Types of significant incidents identified in statute:

1. Conduct on the part of a custodian that is inconsistent with an individual's treatment plan, educational program, or generally accepted treatment practices
2. Conduct between persons receiving services resulting in harm or the potential for harm
3. Any other conduct identified in regulations of the State Oversight Agencies

Non-Reportable Incidents
In 2016, 43,028 reports made to the Justice Center were for non-reportable incidents. These calls are either not an incident because the nature of the allegation did not meet the definition of a reportable incident, involved an incident that occurred in a facility or program that was outside of the agency's jurisdiction or involved a service recipient or staff member who was not under the Justice Center's jurisdiction. Efforts are made to direct callers of non-reportable incidents to an appropriate entity for assistance.

XII. APPENDIX C

Categories of Substantiated Allegations
Substantiated reports of abuse or neglect are categorized into one or more of the following four categories:

Category 1 conduct is: serious physical abuse, sexual abuse or other serious conduct by custodians.

Category 2 conduct is: abuse or neglect that is not included in Category 1, but is conduct by a custodian that *seriously endangers the health, safety or welfare* of a service recipient.

Category 3 conduct is: conduct that is not included in Category 1 or 2, but is nevertheless abuse or neglect.

Category 4 conduct refers to: conditions at a facility or provider agency that expose service recipients to harm or risk of harm but where staff culpability for such abuse or neglect is mitigated by systemic problems, such as inadequate staffing, management, training or supervision. It also applies when abuse or neglect against a service recipient has been substantiated but the responsible person cannot be identified.

Substantiated Determination Consequences
If an allegation of abuse or neglect is substantiated, the subject of that finding has a right to appeal the determination before an administrative law judge.

- **Category 1 Substantiated Findings**: Individuals who have an allegation substantiated in a case of abuse or neglect-- either a single "Category 1" offense or two or more "Category 2" offenses over a 3-year period -- are placed on the Justice Center's Register of Substantiated Category One Case of Abuse or Neglect, also known as the Staff Exclusion List (SEL). Individuals on the SEL are prohibited from being hired by most state operated, certified, or licensed agencies or providers that serve people with special needs. Placement on the SEL is permanent.

- **Category 2 and Category 3 Substantiated Findings**: Substantiated Category 2 findings that are not elevated to a Category 1 finding and all Category 3 findings are sealed after five years.

XIII. APPENDIX D

Justice Center Advisory Council Members

William T. Gettman – Northern Rivers Family of Services (Chair)
Mary E. Bonsignore – Parent Advocate, Bronx Developmental Disabilities Council
Norwig Debye-Saxinger – Therapeutic Communities Association
S. Earl Eichelberger – NYS Catholic Conference
Denise A. Figueroa – Independent Living Center of the Hudson Valley
Leslie A. Hulbert – Parent
Walter J. Joseph, Jr. – Children's Home of Poughkeepsie
Jeremy E. Klemanski – Syracuse Behavioral Health Care
Sylvia Lask – Parent
Ronald S. Lehrer – NYS Association of Boards of Visitors
Glenn Liebman – Mental Health Association in New York State
Joseph Macbeth – National Alliance for Direct Support Professionals
Delores Fraser McFadden – Orange County Department of Mental Health
Kathy O'Keefe – Sagamore Children's Psychiatric Center, Pilgrim Psychiatric Center
Judith A. O'Rourke – Parent
Clint Perrin – Self Advocacy Association of NYS
Susan Platkin – Parent, NY Self Determination Coalition
Harvey B. Rosenthal – NY Association of Psychiatric Rehabilitation Services (NYAPRS)
Mary K. St. Mark – Parent Advocate and Board President, Institutes for Applied Human Dynamics
Euphemia Strauchn-Adams – Parent, Families on the Move
Robert L. Weisman, DO – Strong Memorial Hospital